
State:	Arkansas	Filing Company:	American Fidelity Assurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	A1274, ASI174		
Project Name/Number:	A1274, ASI174/A1274, ASI174		

Filing at a Glance

Company:	American Fidelity Assurance Company
Product Name:	A1274, ASI174
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	08/14/2012
SERFF Tr Num:	AFDL-128631163
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	A1274, ASI174
Implementation	03/01/2013
Date Requested:	
Author(s):	Shari Vick, Melissa Mahanes, Ashlie Snyder, Ann Hobson
Reviewer(s):	Linda Bird (primary)
Disposition Date:	08/20/2012
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

State:	Arkansas	Filing Company:	American Fidelity Assurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	A1274, ASI174		
Project Name/Number:	A1274, ASI174/A1274, ASI174		

General Information

Project Name: A1274, ASI174	Status of Filing in Domicile: Pending
Project Number: A1274, ASI174	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 08/20/2012
	State Status Changed: 08/20/2012
Deemer Date:	Created By: Melissa Mahanes
Submitted By: Melissa Mahanes	Corresponding Filing Tracking Number: A1274, ASI174

Filing Description:

Enclosed for your approval are the above-mentioned forms. These are new forms and do not replace any previously approved forms. The generic application is completed in John Doe fashion. Variable information is marked in brackets [] and an accompanying Statement of Variability is included describing the nature of any variability. The Flesch score, excluding state mandated language, is shown on the Forms Schedule tab. Our captive agents and licensed appointed brokers will use this application for individual life products approved in your state for our payroll markets. We will begin marketing these forms no sooner than March 1, 2013.

These forms may eventually be issued from an automated system. We will make every attempt to produce the automated version to duplicate this final printed format; however, fonts and word wrap can vary when going from one system or printer to another. We will not alter the wording and will try to duplicate all pages, including keeping the verbiage on each page as submitted for approval. The pages may print on different colors of paper depending upon the market.

I hereby certify that to the best of my knowledge the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state and such forms contain no provisions previously disapproved by the Department.

Thank you for your assistance with this matter. If you have any questions, please feel free to call me at contact information shown on the Companies and Contacts tab.

Company and Contact

Filing Contact Information

Melissa Mahanes, Compliance Analyst II	melissa.mahanes@af-group.com
2000 Classen Blvd	800-654-8489 [Phone] 2035 [Ext]
Oklahoma City, OK 73106	405-523-5793 [FAX]

Filing Company Information

American Fidelity Assurance Company	CoCode: 60410	State of Domicile: Oklahoma
2000 North Classen Blvd	Group Code: 330	Company Type: LAH
Oklahoma City, OK 73106	Group Name:	State ID Number:
(405) 523-2000 ext. [Phone]	FEIN Number: 73-0714500	

State: Arkansas**Filing Company:** American Fidelity Assurance Company**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other**Product Name:** A1274, ASI174**Project Name/Number:** A1274, ASI174/A1274, ASI174

Filing Fees

Fee Required? Yes

Fee Amount: \$100.00

Retaliatory? No

Fee Explanation: Arkansas's fee is higher than Oklahoma's fee of \$25/application and \$25/application supplement.

Per Company: No

Company	Amount	Date Processed	Transaction #
American Fidelity Assurance Company	\$100.00	08/14/2012	61652143

SERFF Tracking #:	AFDL-128631163	State Tracking #:		Company Tracking #:	A1274, ASI174
State:	Arkansas	Filing Company:	American Fidelity Assurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	A1274, ASI174				
Project Name/Number:	A1274, ASI174/A1274, ASI174				

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/20/2012	08/20/2012

SERFF Tracking #:	AFDL-128631163	State Tracking #:		Company Tracking #:	A1274, ASI174
State:	Arkansas	Filing Company:	American Fidelity Assurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	A1274, ASI174				
Project Name/Number:	A1274, ASI174/A1274, ASI174				

Disposition

Disposition Date: 08/20/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	John Doe		No
Supporting Document	Statement of Variability		No
Form	Individual Life Application		No
Form	Individual Life Application Supplement		No

State:	Arkansas	Filing Company:	American Fidelity Assurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	A1274, ASI174		
Project Name/Number:	A1274, ASI174/A1274, ASI174		

Form Schedule

Lead Form Number: A1274, ASI174							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		A1274	AEF	Individual Life Application	Initial:	50.000	A1274.pdf
2		ASI174	AEF	Individual Life Application Supplement	Initial:	54.000	ASI174.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

INDIVIDUAL LIFE
PAYROLL APPLICATION

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N Classen Blvd Oklahoma City, Oklahoma 73106

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PROPOSED INSURED INFORMATION

The Proposed Insured is the ☐ Employee (EE) ☐ EE's Spouse ☐ EE's Child ☐ EE's Grandchild
Last Name First Name Full Middle Name Suffix Country of Citizenship

Age Date of Birth Gender Height Weight Soc Sec Number Requested Eff Date EE Date of Employment
Mo Day Yr M F ft. in. lbs. Mo Day Yr Mo Day Yr
☐ ☐

Residence Address (Number & Street) Work Phone # Home Phone # Email Address
() ()
City State Zip

Mailing Address (if different than Residence) City State Zip

Employer of the EE EE Employer MCP # MCH # Occupation of Proposed Insured

1. Does any person to be insured have any existing coverage or pending applications for individual life insurance or annuities with this or any other company? ☐ Yes ☐ No
2. Does any person to be insured intend to replace, discontinue or change any such coverage? ☐ Yes ☐ No
If YES to question 1 OR 2, give company name and policy #, and complete and return any required replacement forms.

PLAN INFORMATION

Death Benefit	Total Premium (base policy plus riders, if any)	Per Billing
<input type="checkbox"/> Whole Life Rider Selection: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Amount \$ <input type="text"/> <input type="checkbox"/> Children's Term Amount \$ <input type="text"/> <input type="checkbox"/> Other Amount \$ <input type="text"/> <input type="checkbox"/> Other Amount \$ <input type="text"/>	<input type="checkbox"/> Year Term Life Rider Selection: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Amount \$ <input type="text"/> <input type="checkbox"/> Children's Term Amount \$ <input type="text"/> <input type="checkbox"/> -Year Term Rider Amount \$ <input type="text"/> <input type="checkbox"/> Other Amount \$ <input type="text"/> <input type="checkbox"/> Other Amount \$ <input type="text"/>	<input type="checkbox"/> Billing Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Other <input type="text"/> Billing Method: <input type="checkbox"/> List Bill Payor # <input type="text"/> Distr ID # <input type="text"/> <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill (Monthly N/A)

If applying for children's term or spouse term rider(s), please complete the appropriate application supplement.

Has the applicant used any form of nicotine in the past 12 months? ☐ Yes (Nicotine) ☐ No (Non-Nicotine)

BENEFICIARY

Primary	First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured	Country of Citizenship
Secondary	First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured	Country of Citizenship

CONTRACT OWNER AND NAME ON BILL (IF OTHER THAN PROPOSED INSURED)

First Name	Full Middle Name	Last Name	Suffix	Social Security or Tax ID #	Date of Birth	Country of Citizenship
Residence Address (Number and Street)		City	State	Zip		

GENERAL QUESTIONS

1. Is the employee actively at work and able to perform the regular duties of his/her occupation? ☐ Yes ☐ No
2. If applying for spouse coverage, is the spouse currently disabled or unable to work due to a medical condition? ☐ Yes ☐ No ☐ N/A
3. If applying for child coverage, is the child disabled or unable to perform the majority of normal activities of a child of like age in good health? ☐ Yes ☐ No ☐ N/A
4. **Within the past 12 months** has any person to be insured been hospitalized (inpatient or outpatient) (excluding ER visits if not admitted to the hospital) **for anything other than** routine well care, pregnancy, or back problems? ☐ Yes ☐ No

MEDICAL QUESTIONS (Must Answer Yes or No for Simplified Issue)

5. **Within the past 3 years** has any person to be insured received treatment (including medication), consulted a physician or medical practitioner, or been hospitalized for, or been medically diagnosed as having: heart or circulatory disorder or abnormality, insulin dependent diabetes, chronic liver or kidney condition (excluding stones), stroke or transient ischemic attack, cancer (excluding non-melanoma skin cancer), pulmonary disease (excluding asthma), 3 or more prescriptions taken for the control of high blood pressure, ALS or any other neurological disorders (excluding headaches or migraines), alcohol or drug addiction or abuse? ☐ Yes ☐ No
6. **Within the past 3 years** has any person to be insured been rated or declined by American Fidelity Assurance Company or any other insurance company? ☐ Yes ☐ No
7. Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been medically diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS related complex (ARC)? ☐ Yes ☐ No

SIGNATURE AND ACKNOWLEDGMENT

Complete For All Applications:

I have received and reviewed a copy of consumer brochure [# SB _____] and the required Accelerated Benefit Summary and Disclosure Notice. I understand that I may be asked to show a government issued photo ID, such as a driver's license in order to identify myself.

The statement and answers given in this application are true, complete and correctly recorded. I understand that the company has issued this coverage in reliance upon the truthfulness of my responses to the questions contained in this application. I have considered my present insurance needs and determined that the purchase of this insurance is suitable for me. You will be covered from the date of your application if on such date you are insurable per our underwriting guidelines for the requested coverage in accordance with the terms of the policy. This interim coverage will remain in force until the policy has been issued or declined.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

Signed At

Date Signed

Signature of Proposed Insured

Signature of Owner (If other than Proposed Insured)

AGENT STATEMENT: To the best of my knowledge the person(s) to be insured ☐ do(es) ☐ do(es) not have any existing individual life insurance or annuity; and, the person(s) to be insured ☐ do(es) ☐ do(es) not intend to replace, discontinue or change any such coverage.

I personally saw the owner and recorded the answers myself. ☐ Yes ☐ No If No, give details _____

Signature of Licensed Agent

Agent's Printed Name and Agent Number

INDIVIDUAL LIFE
SPOUSE/CHILD RIDER
PAYROLL APPLICATION SUPPLEMENT

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N Classen Blvd Oklahoma City, Oklahoma 73106

This supplemental application must be attached to the base policy application, which includes all authorizations and notices.

SPOUSE RIDER INFORMATION (Spouse Must Reside With The Proposed Insured/Employee)

Last Name	First Name	Full Middle Name	Suffix	Country of Citizenship		
Age	Date of Birth Mo Day Yr	Gender M F <input type="checkbox"/> <input type="checkbox"/>	Height ft. in.	Weight lbs.	Soc Sec Number	Death Benefit
Occupation						

Has the Spouse used any form of nicotine in the past 12 months? ☐ Yes (**Nicotine**) ☐ No (**Non-Nicotine**)

SPOUSE RIDER BENEFICIARY INFORMATION

Primary	First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured	Country of Citizenship
Secondary	First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured	Country of Citizenship

CHILDREN TO BE INSURED (All Children Must Be Covered If Eligible)

List all children of the Proposed Insured who are to be covered. The Beneficiary of children's coverage is, in all cases, the Proposed Insured.

Name (Last, First, MI)	Relationship	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Ht Ft. in.	Wt Lbs.	Date of Birth Mo/Day/Yr	SSN	Benefit Amount	Country of Citizenship
		M <input type="checkbox"/> F <input type="checkbox"/>						
		M <input type="checkbox"/> F <input type="checkbox"/>						
		M <input type="checkbox"/> F <input type="checkbox"/>						
		M <input type="checkbox"/> F <input type="checkbox"/>						
		M <input type="checkbox"/> F <input type="checkbox"/>						
		M <input type="checkbox"/> F <input type="checkbox"/>						

SERFF Tracking #:	AFDL-128631163	State Tracking #:		Company Tracking #:	A1274, ASI174
State:	Arkansas	Filing Company:	American Fidelity Assurance Company		
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other				
Product Name:	A1274, ASI174				
Project Name/Number:	A1274, ASI174/A1274, ASI174				

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
12_0810_FlschCert.pdf			
12_0810_CompCert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	John Doe		
Comments:	Attached is a John Doe of the generic application		
Attachment(s):			
A1274_JD.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
12_0810_SoV.pdf			



American Fidelity Assurance Company

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READABILITY CERTIFICATION

I, Michelle Lynch, hereby certify that policy forms enclosed on the Forms filing tab meet the minimum reading ease score required by the Insurance Code in your state. The Flesch Score for each form, excluding state mandated language, is shown on the Forms Schedule Tab.

Form Number	Description	Flesch Score	Word Count	Sentence Count
A1274	Individual Life Insurance Application	50, excluding state mandated language	666	50
ASI174	Individual Life Application Supplement	54, excluding state mandated language	73	6

Michelle Lynch
Assistant Vice President and Compliance Manager

August 10, 2012
Date



STATE OF ARKANSAS

COMPLIANCE CERTIFICATION

Form Number and Name: **A1274 Individual Life Application and ASI174 Individual Life Application Supplement**

I hereby certify that this filing does not discriminate unfairly between Policyholders and that it meets requirements set forth in Arkansas Rule and Regulation 19. I further certify, that to the best of my knowledge and judgment this filing is complete and accurate, and in compliance with the applicable laws and regulations of the State of Arkansas.

A handwritten signature in black ink that reads 'mlynch'.

Michelle Lynch
Assistant Vice President and Compliance Manager

August 10, 2012
Date

AMERICAN FIDELITY ASSURANCE COMPANY
2000 N Classen Blvd Oklahoma City, Oklahoma 73106

[illegible]

The Proposed Insured is the	<input checked="" type="checkbox"/> Employee (EE)	<input type="checkbox"/> EE's Spouse	<input type="checkbox"/> EE's Child	<input type="checkbox"/> EE's Grandchild
Last Name	First Name	Full Middle Name	Suffix	Country of Citizenship

Age	Date of Birth	Gender	Height	Weight	Soc Sec Number	Requested Eff Date	EE Date of Employment
	Mo Day Yr	M F	ft. in.	lbs.		Mo Day Yr	Mo Day Yr
35	1-1-1976	x <input type="checkbox"/>	6 1	185	111-11-1111	6-1-2007	1-1-2001

Anywhere	OK	70000	
Mailing Address (if different than Residence)	City	State	Zip

1. Does any person to be insured have any existing coverage or pending applications for individual life insurance or annuities with this or any other company? ☐ Yes ☒ No

2. Does any person to be insured intend to replace, discontinue or change any such coverage? ☐ Yes ☒ No

If YES to question 1 OR 2, give company name and policy #, and complete and return any required replacement forms.

Death Benefit \$100,000 _____ **Total Premium (base policy plus riders, if any)** \$xxx.xx _____ **Per Billing**

X Whole Life Rider Selection: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Amount \$ _____] <input type="checkbox"/> Children's Term Amount \$ _____] <input type="checkbox"/> Other _____ Amount \$ _____] <input type="checkbox"/> Other _____ Amount \$ _____]	<input type="checkbox"/> _____ Year Term Life Rider Selection: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Amount \$ _____] <input type="checkbox"/> Children's Term Amount \$ _____] <input type="checkbox"/> _____ -Year Term Rider Amount \$ _____] <input type="checkbox"/> Other _____ Amount \$ _____]	<input type="checkbox"/> _____ Rider Selection: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Amount \$ _____] <input type="checkbox"/> Children's Term Amount \$ _____] <input type="checkbox"/> _____ -Year Term Rider Amount \$ _____] <input type="checkbox"/> Other _____ Amount \$ _____]	Billing Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual <input type="checkbox"/> Other _____ Billing Method: <input type="checkbox"/> List Bill Payor # _____ Distr ID # _____ <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill (Monthly N/A)
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If applying for children's term or spouse term rider(s), please complete the appropriate application supplement.

Has the applicant used any form of nicotine in the past 12 months? ☐ Yes (**Nicotine**) ☒ No (**Non-Nicotine**)

Primary	First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured	Country of Citizenship
	George		Doe		Father	United States=
Secondary	First Name	Full Middle Name	Last Name	Suffix	Relationship to Insured	Country of Citizenship

First Name	Full Middle Name	Last Name	Suffix	Social Security or Tax ID #	Date of Birth	Country of Citizenship
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Residence Address (Number and Street)	City	State	Zip
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A1274

1. Is the employee actively at work and able to perform the regular duties of his/her occupation? X Yes ☐ No
2. If applying for spouse coverage, is the spouse currently disabled or unable to work due to a medical condition? ☐ Yes X No ☐ N/A
3. If applying for child coverage, is the child disabled or unable to perform the majority of normal activities of a child of like age in good health? ☐ Yes X No ☐ N/A
4. **Within the past 12 months** has any person to be insured been hospitalized (inpatient or outpatient) (excluding ER visits if not admitted to the hospital) **for anything other than** routine well care, pregnancy, or back problems? ☐ Yes X No

MEDICAL QUESTIONS (Must Answer Yes or No for Simplified Issue)

5. **Within the past 3 years** has any person to be insured received treatment (including medication), consulted a physician or medical practitioner, or been hospitalized for, or been medically diagnosed as having: heart or circulatory disorder or abnormality, insulin dependent diabetes, chronic liver or kidney condition (excluding stones), stroke or transient ischemic attack, cancer (excluding non-melanoma skin cancer), pulmonary disease (excluding asthma), 3 or more prescriptions taken for the control of high blood pressure, ALS or any other neurological disorders (excluding headaches or migraines), alcohol or drug addiction or abuse? ☐ Yes X No
6. **Within the past 3 years** has any person to be insured been rated or declined by American Fidelity Assurance Company or any other insurance company? ☐ Yes X No
7. Has any person to be insured had any positive test results indicating Human Immunodeficiency Virus (HIV), or been medically diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or AIDS related complex (ARC)? ☐ Yes X No

SIGNATURE AND ACKNOWLEDGMENT

Complete For All Applications:

I have received and reviewed a copy of consumer brochure [# SB 12345] and the required Accelerated Benefit Summary and Disclosure Notice. I understand that I may be asked to show a government issued photo ID, such as a driver's license in order to identify myself.

The statement and answers given in this application are true, complete and correctly recorded. I understand that the company has issued this coverage in reliance upon the truthfulness of my responses to the questions contained in this application. I have considered my present insurance needs and determined that the purchase of this insurance is suitable for me. You will be covered from the date of your application if on such date you are insurable per our underwriting guidelines for the requested coverage in accordance with the terms of the policy. This interim coverage will remain in force until the policy has been issued or declined.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information or knowingly presents false information in an application for insurance may be guilty of insurance fraud.

Anywhere, USA _____
Signed At

1/1/13 _____
Date Signed

John Doe _____
Signature of Proposed Insured

Signature of Owner (If other than Proposed Insured)

AGENT STATEMENT: To the best of my knowledge the person(s) to be insured ☐ do(es) X do(es) not have any existing individual life insurance or annuity; and, the person(s) to be insured ☐ do(es) X do(es) not intend to replace, discontinue or change any such coverage.

I personally saw the owner and recorded the answers myself. ☐ Yes X No If No, give details _____

Joe Agent _____
Signature of Licensed Agent

Joe Agent 1234 _____
Agent's Printed Name and Agent Number



American Fidelity Assurance Company

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STATEMENT OF VARIABILITY

The enclosed contains variable information. All forms are completed in John Doe format and variable information is enclosed in brackets []. All variable items will become fixed at time of policy approval. Any changes made to these items will be limited to new issues.

A1274

1. We currently market 4 Optional Benefit Riders: Waiver of Premium, Accidental Death Benefit, Children's Term Insurance Rider and Spouse Term Insurance Rider. Variability for these items is limited to whether or not the rider selections will print on the final application.

The A1274 also includes rider lines marked "Other" for future rider flexibility. Any new riders which may be offered with this plan will be filed with your department prior to use with an explanation of what information will print in these selections.

2. The brochure form number has been marked variable. Although it is unlikely to change, we may use a different form number in the future.

Melissa Mahanes

Melissa Mahanes
Compliance Analyst II

8/10/12

Date